STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 06/16/2016

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CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

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F 000	INITIAL COMMENTS During a complaint investigation of #38845, #38850, and #38920 conducted 5/16/16 through 6/16/16, at Creekside Health and Rehabilitation Center, no deficiencies were cited in relation to complaints #38850 and #38920, under 42 CFR PART 483, Requirements for Long Term Care Facilities. Deficiencies were cited for complaint #38845 at a Harm level.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F 157** **SS=G** **483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Requirement:** The facility will immediately inform the resident; consult with the resident's physician, and if known, notify the resident's legal representative; or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status.(i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Treadaway | TITLE: Administrator | (X6) DATE: 7/5/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to notify the physician of a pressure ulcer for 1 (Resident #1) resident of 12 residents reviewed for pressure ulcers. The facility's failure to notify the physician of the pressure ulcer resulted in Actual Harm to Resident #1. The findings included: Facility policy review titled Wound Care Management, dated 3/13/15 revealed, "...Notify the...physician...of the presence of the wound and if the resident...has a negative change in the wound appearance..." Medical record review revealed Resident #1 was admitted to the facility on 2/15/16, discharged on 3/12/16, readmitted on 3/16/16 and discharged to the hospital on 5/9/16. Diagnoses included End Stage Renal Disease, Generalized Muscle Weakness, Unsteadiness on Feet, Hypertension, Glaucoma, Anxiety and Depression. Medical record review of the Admission Minimum Data Set (MDS) dated 3/23/16 revealed the resident had a Brief Interview for Mental Status score of 15/15 indicating the resident was cognitively intact. Continued review of the MDS revealed the resident had no pressure ulcers and was always incontinent of urine and bowel.	F 157	The facility will also promptly notify the resident and if known, their resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in 483.15€(2); or a change in resident rights under federal or state law or regulations as specified in paragraph (b)(1) of this section. The facility will record and periodically update the address and the phone number of the resident's legal representative or interested family member. **Correction Action:** 1. Resident #1 was transferred to the hospital on 5/9/16 and did not return. 2. (a) Skin audits were conducted by the Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, Unit Managers, and MDS Coordinators for 100 % of the facility residents on 5/19/16 – 5/26/16 to verify no other residents were affected. (b) On 6/21/16 and 6/22/16, an audit was done on the weekly skin inspections for 100% of the facility residents by the Regional Director of Clinical Services with no other residents identified as being affected.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157	Continued From page 2 Medical record review of the Post Hospitalization Transition Discharge Instructions from the discharging hospital dated 3/16/16 revealed documentation of a "Sacrum Stage one pressure ulcer, treated with repositioning and a mepilex (foam dressing)". Medical record review of the Nursing Admission Assessment dated 3/17/16 at 4:27 AM by Licensed Practical Nurse (LPN) #1, revealed documentation of the presence of a "Pressure Ulcer" in the skin portion of the assessment for Resident #1. Medical record review of the Departmental Notes dated 3/17/16 at 10:39 AM, by LPN #2, documented "...late entry for 3/16/16: resident also has noted open area on coccyx..." Medical record review of the Skin Concerns Roster dated 3/17/16 at 5:27 PM by RN #1 revealed, "Yes skin concern-nurse notified." Medical record review of the Skin Inspection Report for Resident #1 dated 2/15/16 through 5/4/16 revealed the following: 3/17/16 "Skin Not Intact-Existing" by LPN #3 4/22/16 "Skin Not Intact-New" by RN #2 4/27/16 "Skin Not Intact-Existing" by LPN #4 5/4/16 "Skin Not Intact-Existing" by LPN #4 Medical record review of the Wound Assessment Report by LPN #5 dated 4/19/16 revealed Resident #1 had an abrasion to the coccyx that was identified on 4/19/16. There was no drainage; the wound measured 1.50 cm (centimeters) in length, 2.70 cm in width, and had	F 157	3. (a) On 5/19/16 – 5/29/16, education regarding "Notification of Change" was completed with all licensed staff by the RN Staff Development Coordinator. (b) Additionally, all new hired nurses will receive education regarding notification of changes guidelines for pressure ulcers, according to facility guidelines, during their orientation by the RN Staff Development Coordinator. (c) The Treatment nurse will ensure appropriate and timely notification of changes in wound status, is made to the RP and MD as indicated. 4. (a)The Director of Nursing/Designee will monitor documentation for the notification process to ensure appropriateness and timeliness of communication is maintained with the RP and MD regarding changes in wound status. (b) The Director of Nursing/Designee will monitor daily x 30 days; 5 x week x 8 weeks and weekly x 8. (c) The Director of Nursing/designee will report monitoring results to the QAPI Committee (at a minimum includes the Medical Director, DON, Administrator, MDS Coordinator, Social Services Activities Director and Maintenance) and if compliance is not met, the licensed staff will be re-educated and the monitoring will continue. Completed 6/23/16	

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F 157	Continued From page 3 a depth of 0.10 cm. Medical record review of the Wound Assessment Report completed by the Wound Nurse dated 5/4/16 revealed the wound type was an abrasion; wound location was coccyx; wound status was deteriorated; a small amount of serosanguinous (yellowish with small amounts of blood) drainage was present; the wound measured 4.00 cm in length, 4.50 cm in width and 0.10 cm in depth; description of the skin irritation/excoriation was documented as "Red or darker pink, moderate irritation". Medical record review of the Wound Assessment Report completed by the Wound Nurse, dated 5/9/16, revealed the wound status was unchanged; the wound type was an abrasion; wound location was the coccyx; a small amount of serosanguinous drainage and was documented as to have no infection or pain. The measurements remained unchanged from the previous assessment on 5/4/16. Medical record review revealed no documentation in the Physician Progress Notes that a wound to the sacrum (coccyx) was identified or followed up on for Resident #1 by the physician or nurse practitioner. Telephone interview with the Medical Director (MD) on 5/19/16 at 7:54 AM revealed the MD was unaware of any type of wound for Resident #1. The MD was asked if the Wound Nurse had contacted him on 4/19, 4/27, 5/4 and 5/9 regarding a wound to the coccyx with an increase in size and drainage for Resident #1. The MD stated, "No, I definitely was not called 4 times. I was not aware of any problems until the Director	F 157		

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F 157	Continued From page 4 of Nursing (DON) called me yesterday to ask me if I knew anything about a shearing problem for (named Resident #1). I told her no, this is the first I've heard of it." Interview with Nurse Practitioner (NP) #2 on 5/19/16 at 9:45 AM, in the Physician's Office at the facility, revealed the NP was present in the facility 5 days a week. The NP stated, "I never knew of any wound to (named Resident #1) and I work very closely with (named MD) and I can attest that he never knew anything either. (Named MD) and I rounded on Sunday 5/8/16 and (named Resident #1) was somnolent but arousable over 5/7/16 and 5/8/16. She had a gradual decline over the last week. I absolutely did not know about this." Interview with NP #3 on 5/19/16 at 10:00 AM in the Physician's Office at the facility revealed NP #3 had no knowledge of an abrasion, wound or pressure ulcer to Resident #1. Telephone interview with NP #1 on 5/19/16 at 11:40 AM revealed the NP was nationally certified as a Wound Care and Ostomy Specialist. The NP denied having any knowledge of an abrasion, wound, or pressure ulcer to the coccyx of Resident #1. The NP referred to her notes and stated she had treated the resident for leg pain but no other problems were brought to her attention. The NP was asked if she was notified on 5/4/16 by the Wound Nurse regarding the increase in size and drainage to the wound on the resident, the NP stated, "No, I knew nothing about it. I received a list on 5/6/16 with (named resident) name on it to round on for Tuesday 5/10/16 but it is circled because I never saw her, and I thought she was at dialysis." The NP	F 157		

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F 157	Continued From page 5 continued to state she was present at the facility on Monday 5/2/16, Friday 5/6/16, and on Monday 5/9/16 and nothing was ever communicated to her about a wound or any other concern with the resident. The NP stated, "I only know if the staff communicate to me or another NP, but I had no knowledge of this." Further interview with NP #1 on 5/24/16 at 7:37 AM revealed the NP stated, "I depend on the nurses to let me know there is a problem. There is a Communication Book for the NP's that the nurses can write their problems or concerns, but (named Resident #1) wasn't listed and I never got anything on her." Review of the Hermitage Nurse Station Communication Book dated 3/16/16-5/9/16 revealed no skin concerns were documented for Resident #1. Interview with the Wound Nurse on 6/14/16 at 8:40 AM in the Conference Room, when asked if the MD or NP were notified of a wound for Resident #1 at any time the resident was in the facility, revealed the Wound Nurse stated, "No, not from me." The facility's failure to notify the physician of a pressure ulcer resulted in Actual Harm to Resident #1.	F 157		
F 278 SS=G	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		

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F 278	Continued From page 6 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assess the presence of a pressure ulcer on the Minimum Data Set (MDS) for 1 (Resident #1) resident of 12 residents reviewed for pressure ulcers. The facility's failure to assess the presence of a pressure ulcer resulted in Actual Harm to Resident #1. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 2/15/16, discharged on 3/12/16, readmitted on 3/16/16 and discharged to the hospital on 5/9/16. Diagnoses included End	F 278	**F 278.** **483.20(g) – (j) ASSESSMENT, ACCURACY/COORDINATION/CERTIFIED** **SS=G** **Requirement:** The facility will ensure that assessments are accurate and reflect the resident's status. A registered nurse will conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse will sign and certify that the assessment is completed. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment. **Correction Action:** 1. Resident #1 was transferred to the hospital on 5/9/16 and did not return. 2. (a)On 6/22/16 and 6/23/16, an audit was conducted on the MDSs' for 100% of residents with pressure ulcer/wounds, for accuracy of assessments to reflect the resident's status, by the Regional Director of Clinical Services.	

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F 278	Continued From page 7 Stage Renal Disease, Generalized Muscle Weakness, Unsteadiness on Feet, Hypertension, Glaucoma, Anxiety and Depression. Medical record review of the Post Hospitalization Transition Discharge Instructions from the discharging hospital dated 3/16/16 revealed documentation of a "Sacrum Stage one pressure ulcer, treated with repositioning and a mepilex (foam dressing)". Medical record review of the Nursing Admission Assessment dated 3/17/16 at 4:27 AM by Licensed Practical Nurse (LPN) #1 revealed documentation of the presence of a "Pressure Ulcer" in the skin portion of the assessment for Resident #1. Medical record review of the Nursing Risk Assessment dated 3/17/16 at 9:51 AM revealed it was completed by Registered Nurse (RN) #1. Continued review of the Nursing Risk Assessment revealed a Visual Body Map documenting Resident #1 had an "abrasion" to the left gluteal coccyx area (low buttock/back area). Medical record review of the Departmental Notes dated 3/17/16 at 10:39 AM revealed LPN #2 documented "...late entry for 3/16/16: resident also has noted open area on coccyx..." Medical record review of the Skin Inspection Report for Resident #1 dated 3/17/16 revealed "Skin Not Intact-Existing" by LPN #3. Medical record review of the Skin Concerns Roster dated 3/17/16 at 5:27 PM by RN #1 revealed "Yes skin concern-nurse notified."	F 278	3. (a) On 6/20/16, the MDS Coordinators were educated by the Regional Director of Clinical Compliance, on the significance of and process for MDS assessment accuracy for all residents. (b) MDS Coordinators will ensure all assessments are accurate and reflect the presence of residents' wound and status on admissions, with quarterly assessments, with significant changes and as indicated. 4. (a)The Director of Nursing/Designee will monitor MDS assessments for wounds and wound care accuracy weekly x 8 weeks and monthly x 3. (b) The Director of Nursing/designee will report monitoring results to the QAPI Committee (at a minimum includes the Medical Director, DON, Administrator, MDS Coordinator, Social Services Activities Director and Maintenance) and if compliance is not met, the MDS Coordinators will be re-educated and the monitoring will continue. Completed 6/23/16	

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F 278	Continued From page 8 Medical record review of the Admission Minimum Data Set (MDS) dated 3/23/16 revealed no documentation of the presence of a pressure ulcer. Interview with MDS Coordinator LPN #6 on 6/13/16 at 12:30 PM in the MDS office, when asked how the MDS Coordinator obtained information for a comprehensive admission assessment, LPN #6 stated, "I look at the wound care information, the wound treatment sheets, nurses notes, hospital documentation, NP [Nurse Practitioner] notes, interviews with the resident, family, and staff. I look at the entire chart." LPN #6 was shown the documentation in the resident's medical record indicating a Stage 1 pressure ulcer was present upon admission. LPN #6 stated, "I generally look at the wound care nurse's notes. In hind sight I would make it a Stage I." Continued interview with LPN #6 confirmed the Admission MDS was inaccurate and did not document the presence of a pressure ulcer for Resident #1. Interview with the Director of Clinical Services on 6/15/16 at 9:15 AM in the Conference Room confirmed the MDS nurse should have looked at multiple sources available in the resident's medical record to identify a Stage I pressure ulcer to Resident #1. Continued interview confirmed the facility failed to provide an accurate comprehensive assessment for Resident #1. The facility's failure to assess the presence of a pressure ulcer resulted in Actual Harm to Resident #1.	F 278		

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F 279 F 279 SS=G	Continued From page 9 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a comprehensive care plan for the care and treatment of a pressure ulcer for 1 (Resident #1) resident of 12 residents reviewed. The facility's failure to complete a comprehensive care plan resulted in Actual Harm to Resident #1. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 2/15/16, discharged on	F 279 F 279	**F 279** **483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **SS=G** **Requirement:** A facility must use the results of the assessment to develop, review and revise the resident's comprehensive care plan. The facility must develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under 483.25; and any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4).	

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F 279	Continued From page 10 3/12/16, readmitted on 3/16/16 and discharged to the hospital on 5/9/16. Diagnoses included End Stage Renal Disease, Generalized Muscle Weakness, Unsteadiness on Feet, Hypertension, Glaucoma, Anxiety, and Depression. Medical record review of the Post Hospitalization Transition Discharge Instructions from the discharging hospital dated 3/16/16 revealed documentation of a "Sacrum Stage one pressure ulcer, treated with repositioning and a mepilex (foam dressing)". Medical record review of the Nursing Admission Assessment dated 3/17/16 at 4:27 AM by Licensed Practical Nurse (LPN) #1 revealed documentation of the presence of a "Pressure Ulcer" for Resident #1. Medical record review of the Nursing Risk Assessment dated 3/17/16 at 9:51 AM revealed it was completed by Registered Nurse (RN) #1. Continued review of the Nursing Risk Assessment revealed a Visual Body Map that documented Resident #1 had an "abrasion" to the left gluteal coccyx area (low buttock/back area). Medical record review of the Departmental Notes dated 3/17/16 at 10:39 AM revealed LPN #2 documented "...late entry for 3/16/16: resident also has noted open area on coccyx..." Medical record review of the Skin Concerns Roster dated 3/17/16 at 5:27 PM by RN #1 revealed "Yes skin concern-nurse notified." Medical record review of the Skin Inspection Report for Resident #1 dated 3/17/16 revealed "Skin Not Intact-Existing" by LPN #3.	F 279	**Correction Action:** 1. Resident #1 was transferred to the hospital on 5/9/16 and did not return. 2. (a)On 6/24/16 and 6/25/16, an audit was conducted by the MDS Coordinator, treatment nurses and nurse manager, regarding the care plans for 100% of residents with pressure ulcer/wounds, to ensure they are current and reflect care and treatment of any pressure areas present. (b) Care plans were updated to reflect wound care and treatment, if it was indicated.	

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F 279	Continued From page 11 Medical record review of the comprehensive care plan dated 2/16/16 revealed the resident was at risk for skin breakdown. Continued review of the comprehensive care plan revealed no care plan for the care and treatment of a pressure ulcer when the resident was admitted to the facility on 3/16/16. Interview with Minimum Data Set (MDS) RN #3 and LPN #6 on 6/13/16 at 12:45 PM in the MDS office confirmed the MDS nurses were responsible for initiating the comprehensive care plan upon admission of a resident. Continued interview, in reference to the Stage I pressure ulcer to Resident #1, LPN #6 stated "It wasn't mentioned in the MDS and unless the wound nurse or someone else tells us, we weren't aware of the problem". Interview with the Director of Clinical Services on 6/15/16 at 9:15 AM in the Conference Room confirmed the comprehensive care plan for Resident #1 did not address the presence of a Stage 1 pressure ulcer upon admission to the facility on 3/16/16. The facility's failure to complete a comprehensive care plan for the care and treatment of a pressure ulcer resulted in Actual Harm to Resident #1.	F 279	3. On 6/20/16, the MDS Coordinators were educated by the Regional Director of Clinical Services, regarding facility guidelines for care plan development and updating to maintain current status of wounds and wound treatment. (b) MDS Coordinators will ensure comprehensive care plans are accurate and reflect the residents' wound status on admission, quarterly and with any significant changes, according to facility guidelines. (C) All new admissions will be assessed for wounds by the treatment nurse, charge nurse or designee and care plan will be modified by MDS Coordinator, as indicated. 4. (a)The Director of Nursing/Designee will monitor admission care plan development and updating for wounds and wound care weekly x 8 weeks and monthly x 3. (b) The Director of Nursing/designee will report monitoring results to the QAPI Committee (at a minimum includes the Medical Director, DON, Administrator, MDS Coordinator, Social Services Activities Director and Maintenance) and if compliance is not met, the MDS Coordinators will be re-educated and the monitoring will continue. Completed 7/1/16	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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F 314	Continued From page 12 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on facility policy and protocol review, medical record review, interview, and hospital medical record review, the facility failed to timely identify, provide treatment and prevent deterioration of a pressure ulcer for 1 (Resident #1) resident of 12 residents reviewed for pressure ulcers. The facility's failure to timely identify, provide treatment and prevent deterioration of a pressure ulcer resulted in Actual Harm to Resident #1. The findings included: Review of the facility policy titled Skin Program Policy, undated, revealed, "Skin problems are minimized to the greatest extent possible through an aggressive approach consisting of four components. They are: 1. Prevention, evaluation and screening 2. Ongoing surveillance 3. Treatment orders 4. Treatment protocol ...Each resident is evaluated for...skin care at the time of admission...all residents receive a weekly skin integrity check performed by licensed personnel...all disciplines are alerted immediately if the resident...is at risk for the development of skin breakdown. The nursing department coordinates the response to the resident needs	F 314	**F 314** **483.25(C) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCERS** **SS=G** **Requirement:** Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressures sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	

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F 314	Continued From page 13 (in the area of skin integrity) by the following means...With an array of preventative measures practiced on the resident's behalf when the resident has been identified as being at risk...The admitting nurse completes a Braden skin and Pressure risk assessment...shows the resident to be 'at risk' or prone to skin breakdown...the Pressure Ulcer Prevention Checklist is implemented. Protocols for prevention of skin breakdowns are included on the Pressure Ulcer Prevention Checklist that should be completed...With each dressing change or at least on a weekly assessment will be made addressing at least the following per policy and procedure. 1. Site 2. Stage I, II, III, IV, Deep Tissue Injury, Unstageable 3. Size, diameter, depth and edges 4. Presence or absence of drainage, undermining 5. Presence or absence of odor, {necrotic} tissue type or amount 6. Skin color surrounding wound 7. {Peripheral} Tissue Edema 8. {Peripheral} Tissue Induration 9. Granulation Tissue 10. Epithelialization 11. Response to treatment or progress 12. Dietary and physician notified 13. Responsible Party Notified..." Review of the facility protocol titled Pressure Ulcer Protocol, undated, revealed, "Prevention Protocol: Pressure relief; Skin care...Assessment; Incontinence Status; Resident Mobility; Resident and Family Education...Intervention...Repositioning in bed	F 314	**Correction Action:** 1. Resident #1 was transferred to the hospital on 5/9/16 and did not return. 2. (a) Skin assessments were conducted by the Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, Unit Managers, and MDS Coordinators for 100 % of the facility residents on 5/19/16 – 5/26/16 to verify no other residents were affected. (b) On 6/21/16 and 6/22/16, an audit was done regarding the weekly skin inspections for 100% of the facility residents by the Regional Director of Clinical Services to verify no other residents were affected.	

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F 314	Continued From page 14 every 1-2 hours and in chair every 30 minutes; Wrinkle and debris free linen...Bowel and bladder management regimen...Educate resident...weight shifting in bed and chair, teach to turn if possible...Chart initial assessment of pressure ulcer noting: location, stage, size, depth, absence or presence of pain, absence or presence of pressure, exudate (if present), wound bed, description of wound edges. Daily monitoring includes...Evaluation of dressing if present...The presence of complications such as signs of increasing areas of ulcerations or infections or leaking around the wound..." Review of the Hartmann Wound Care Protocol attached to the Pressure Ulcer Protocol provided by the facility revealed, "Category/Stage I: Non-blanchable erythema Epidermis is intact...Treatment objective: Prevent any further damage to the resident's skin...Treatment Option 1...*Appropriate support service for Stage 1 *Moisturizing cream or ointment...Treatment Option 2 *Appropriate support surface...Thin hydrocolloid dressing, a gel sheet dressing or a transparent film dressing...Category/Stage II: Partial thickness ulcer penetrating the epidermis and possibly into, but not through the dermis...*Sacral wounds* Use PermaFoam DO NOT use Hydrocolloid...Treatment Objective: Prevent furter damage and create an environment conducive to re-epithelialization...Treatment Option 2 Stage II-Abrasion or shallow crater wound producing a minimal to moderate amount of drainage...*Hydrocolloid dressing, gel sheet dressing or foam dressing...Gently cleanse the wound with normal saline or wound cleanser...Place the dressing over the center of the wound...Change the dressing every 3-4 days	F 314	3. (a) On 5/19/16 – 5/29/16, all staff was educated by the RN Staff Development Coordinator regarding recognizing and identifying skin changes, accuracy of assessing skin and documentation to ensure timely identification of pressure ulcer. (b) Additionally, all new hired nurses will receive education regarding recognizing pressure ulcers and initiating proper treatment according to facility guidelines, during their orientation by the RN Staff Development Coordinator. (C) On 6/23/16, the Treatment nurse received education by the MDS Coordinator who has WCC credentials, regarding proper staging and treatment protocol. On 6/24/16, the treatment nurse was audited by treatment observation for three different residents by the MDS Coordinator, WCC.	

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F 314	Continued From page 15 or if the dressing begins to leak...Turn the resident every 2 hours..." Review of the facility prevention policy attached to the Pressure Ulcer Protocol and the Hartmann Wound Care protocol provided by the facility titled "Protecting Against the Adverse Effects of External Mechanical Forces, Pressure, Friction and Shear is another goal in the prevention of pressure ulcers...Any individual in bed who is assessed to be at risk for developing pressure ulcers should be REPOSITIONED at least every 2 hours...A written plan for systematically turning and repositioning...should be used...Using LIFTING DEVICES such as a trapeze or bed linen to move (rather than drag) individuals in bed who cannot assist during transfers and position changes...A written plan for the use of positioning devices is helpful for chair-bound individuals." Medical record review revealed Resident #1 was admitted to the facility on 2/15/16, discharged on 3/12/16, readmitted on 3/16/16 and discharged to the hospital on 5/9/16. Diagnoses included End Stage Renal Disease, Generalized Muscle Weakness, Unsteadiness on Feet, Hypertension, Glaucoma, Anxiety and Depression. Medical record review the Post Hospitalization Transition Discharge Instructions from the discharging hospital dated 3/16/16 revealed documentation of a "Sacrum Stage one pressure ulcer, treated with repositioning and a mepilex (foam dressing)". Medical record review of the Admission Minimum Data Set (MDS) dated 3/23/16 revealed the resident had a Brief Interview for Mental Status score of 15/15 indicating the resident was	F 314	4. (a)The Director of Nursing/Designee will conduct an audit of skin inspections, at least 10 per week x 12 weeks to ensure completion and reflective of current resident status. (b) The Director of Nursing/designee will report monitoring results to the QAPI Committee (at a minimum includes the Medical Director, DON, Administrator, MDS Coordinator, Social Services Activities Director and Maintenance) and if compliance is not met, the licensed staff will be re-educated and the monitoring will continue. Completed 7/1/16	7/1/16

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F 314	Continued From page 16 cognitively intact. Continued review revealed the resident required extensive assistance for bed mobility and transfers, had no pressure ulcers and was always incontinent of urine and bowel. Medical record review of the comprehensive care plan dated 2/16/16 revealed the resident was at risk for skin breakdown. Continued review of the comprehensive care plan revealed no care plan for the care and treatment of a pressure ulcer when the resident was admitted to the facility on 3/16/16. Medical record review of the Nursing Admission Assessment dated 3/17/16 at 4:27 AM by Licensed Practical Nurse (LPN) #1 revealed documentation of the presence of a "Pressure Ulcer" for Resident #1. Medical record review of the Nursing Risk Assessment dated 3/17/16 at 9:51 AM revealed it was completed by Registered Nurse (RN) #1. Continued review of the Nursing Risk Assessment revealed a Visual Body Map that documented Resident #1 had an "abrasion" to the left gluteal coccyx area (low buttock/back area). Medical record review of the Departmental Notes dated 3/17/16 at 10:39 AM revealed LPN #2 documented "...late entry for 3/16/16: resident also has noted open area on coccyx..." Medical record review of the Skin Concerns Roster dated 3/17/16 at 5:27 PM by RN #1 revealed "Yes skin concern-nurse notified." Medical record review of the Skin Inspection Report for Resident #1 revealed the following:	F 314		

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F 314	Continued From page 17 3/17/16 "Skin Not Intact-Existing" by LPN #3 4/22/16 "Skin Not Intact-New" by RN #2 4/27/16 "Skin Not Intact-Existing" by LPN #4 5/4/16 "Skin Not Intact-Existing" by LPN #4 Continued medical record review revealed no physician's order to treat the open area on the coccyx until 4/19/16. Medical record review of the Wound Assessment Report by LPN #5 dated 4/19/16 revealed Resident #1 had an abrasion to the coccyx that was identified on 4/19/16. There was no drainage; the wound measured 1.50 cm (centimeters) in length, 2.70 cm in width, and had a depth of 0.10 cm. Interview with LPN #5 on 5/18/16 at 8:40 AM in the day room on Unit 5 revealed the LPN stated she was notified by a Certified Nurse Aide (CNA) about the wound to Resident #1's coccyx area on 4/19/16. Medical record review of the Physician's Telephone Order dated 4/19/16 revealed "clean coccyx buttocks [with] wc (wound cleanser), pat dry & apply hydrocolloid q (every) 3 days". Medical record review of the Wound Assessment Report completed by the Wound Nurse dated 5/4/16 revealed the wound type was an abrasion; wound location was coccyx; wound status was deteriorated; a small amount of serosanguinous (yellowish with small amounts of blood) drainage was present; the wound measured 4.00 cm in length, 4.50 cm in width and 0.10 cm in depth; description of the skin irritation/excoriation was documented as "Red or darker pink, moderate irritation."	F 314		

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F 314	Continued From page 18 Medical record review of the Wound Assessment Report completed by the Wound Nurse dated 5/9/16 revealed the wound status was unchanged; the wound type was an abrasion; wound location was the coccyx; a small amount of serosanguinous drainage and was documented as to have no infection, or pain. The measurements remained unchanged from the previous assessment on 5/4/16. Interview with the Wound Nurse on 5/18/16 at 8:00 AM in the Day room on Unit 5 confirmed the wound "got bigger by a couple of centimeters." Continued interview revealed the Wound Nurse stated "I did include (named Resident #1) on the list to round on for Tuesday 5/10/16 because I was concerned the wound grew bigger, and had drainage, and was not responding to treatment." Further interview revealed the Wound Nurse stated, "I should have changed it to a Stage II on 5/4, but I was waiting to round with the NP on 5/10 to make sure what it was." Interview with CNA #1 on 5/18/16 at 10:40 AM in the Conference Room revealed the CNA stated, "She did have a pink spot on her bottom, then an abrasion with a layer of skin gone. I'm not sure how it happened." Continued interview revealed the wound "did open up some. She did have a wound on her coccyx and it got worse..." Telephone interview with the Medical Director, (MD) on 5/19/16 at 7:54 AM revealed the MD was unaware of any type of wound for Resident #1. The MD was asked if the Wound Nurse had contacted him on 4/19/16, 4/27/16, 5/4/16 and 5/9/16 as documented on the Wound Assessment Reports for those dates. The MD	F 314		

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stated, "No, I definitely was not called 4 times. I was not aware of any problems until the Director of Nursing (DON) called me yesterday to ask me if I knew anything about a shearing problem for (named Resident #1). I told her no, this is the first I've heard of it."

Interview with NP #2 on 5/19/16 at 9:45 AM in the Physician's Office at the facility revealed the NP was present in the facility 5 days a week. The NP stated, "I never knew of any wound to (named Resident #1), and I work very closely with (named MD), and I can attest that he never knew anything either. (Named MD) and I rounded on Sunday 5/8/16 and (named Resident #1) was somnolent but arousable over 5/7/16 and 5/8/16. She had a gradual decline over the last week. I absolutely did not know about this."

Interview with NP #3 on 5/19/16 at 10:00 AM in the Physician's Office at the facility stated she had no knowledge of any abrasion, wound or pressure ulcer to Resident #1.

Medical record review revealed no documentation in the Physician Progress Notes that a wound to the sacrum (coccyx) was identified or followed up on for Resident #1 by the physician or nurse practitioner.

Interview with the DON on 5/19/16 at 10:18 AM in the Conference room revealed the DON was shown the documentation from the transferring hospital on the Post Hospitalization Transition Discharge Instructions for Resident #1 dated 3/16/16 that documented under Skin and/or Wound care, "Sacrum; Stage one pressure ulcer, treated with repositioning and a mepilex." Further interview revealed the DON was asked about the

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F 314	Continued From page 20 nursing documentation by 4 different nurses that had documented on 3/17/16 the resident had a pressure ulcer, open area on the coccyx, skin not intact-existing, and skin concern nurse notified. The DON did not respond. Telephone interview with NP #1 on 5/19/16 at 11:40 AM revealed the NP was nationally certified as a Wound Care and Ostomy Specialist. The NP denied having any knowledge of an abrasion, wound or pressure ulcer to the coccyx of Resident #1. The NP referred to her notes and stated she had treated the resident for leg pain but no other problems were brought to her attention. The NP was asked if she was notified on 5/4/16 by the Wound Nurse regarding the increase in size and drainage to the wound on the resident, the NP stated, "No, I knew nothing about it. I received a list on 5/6/16 with (named resident) name on it to round on for Tuesday 5/10/16 but it is circled because I never saw her, and I thought she was at dialysis." The NP continued to state she was in the facility on Monday 5/2/16, Friday 5/6/16, and on Monday 5/9/16, and nothing was ever communicated to her about a wound or any other concern with the resident. The NP stated, "I only know if the staff communicate to me or another NP, but I had no knowledge of this." Review of the hospital Emergency Provider Report dated 5/9/16 revealed the resident arrived at the Emergency Room at 11:33 AM for complaint of decreased alertness. The resident was admitted to the hospital at 2:25 PM. Review of the hospital Consultation Report from an Infectious Disease Physician dated 5/10/16 revealed the reason for the consultation was	F 314		

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F 314	Continued From page 21 "Sepsis with infected decubitus ulcer." Continued review revealed "...She has now been found also to have a very necrotic foul-smelling decubitus in the sacral gluteal area and wound care and infectious consultation has been requested...Examination of the sacral coccygeal gluteal area shows necrotic skin with mushy fluctuant tissues under the skin and an open hanging out fatty tissue in the coccygeal area with various foul malodorous drainage, obtained cultures...This will need to be surgically debrided for source control...". Continued review revealed an Assessment/Plan by the infectious disease physician dated 5/11/16 which stated, "...Septic shock/severe sepsis...Decubitus ulcer of coccygeal region, unstageable, likely stage 4 infected...Continued review of the hospital medical record revealed a Hospitalist Progress Note dated 5/13/16 which documented, "Decubitus Ulcer of coccygeal region unstageable...PRESENT ON ADMISSION...5/10 WOUND [Culture] [E-COLI, ESBL] (bacteria that normally lives in the intestines of people; resistant bacteria)..." Telephone Interview with NP #1 on 5/24/16 at 7:37 AM revealed NP #1 when asked about the abrasion to the coccyx area, the NP stated, "An abrasion is a Stage II pressure ulcer in that location." The NP was asked if a Stage II pressure ulcer can develop into a "Stage IV pressure ulcer with foul, odorous smelling drainage with tissue hanging out" in an 8-10 hour time frame. The NP stated, "No. I think the ulcer was already there when the resident was at the facility and had been there. When explored you will find a Stage III or Stage IV. I suspect this was the scenario for (named resident). It looked like an abrasion, but obscured by the skin color. It	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	C 06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 22 doesn't happen quick. The wound nurses didn't recognize what they were seeing, it was a knowledge deficit. They thought it was simple but it was not." The NP was asked if she was aware of a skin problem for Resident #1 and she stated, "I was not. No one notified me. I depend on the nurses to let me know there is a problem. There is a Communication Book for the NP's that the nurses can write their problems or concerns, but (name resident) wasn't listed and I never got anything on her." Review of the Hermitage Nurse Station Communication Book dated 3/16/16-5/9/16 revealed no skin concerns were documented for Resident #1. Telephone interview with the Infectious Disease Physician on 6/16/16 at 1:00 PM revealed the physician had consulted on Resident #1 on 5/10/16 at the hospital the facility discharged the resident to on 5/9/16. Continued interview revealed the Physician stated the pressure ulcer to the coccyx "had to be a pre-existing condition for sure with necrotic tissue underneath. It can be stable to a point, but it doesn't happen from an abrasion. It must have been from a deep tissue injury, but not from an abrasion." The facility's failure to timely identify, provide treatment and prevent deterioration of a pressure ulcer resulted in Actual Harm to Resident #1.	F 314		